Georgia
State Personnel Administration

Flexible Benefits Program
Qualifying Change in Status Form

Please read the Terms and Conditions on the last page of this form prior to completing.

Type or print clearly in ink and return to your personnel or payroll office.

<table>
<tr><td colspan="2">Employee Information
(Please complete in full the requested information below)</td><td>Reason for Change(s) in Coverage
Check the box that best describes the reason for this action and give the date of the qualifying event. Attach documentation supporting your qualifying event request.</td></tr>
<tr><td>Social Security Number</td><td>Date of Birth (00/00/0000)</td><td rowspan="5">Date of Event _____

_____Marriage/Marriage Causing Dual Coverage
_____Divorce
_____Loss of all Eligible Dependents
_____Gain of Eligible Dependents
_____Loss/Gain of Spouses Coverage – Employment Change
_____Moving from Dental PPO Service Area
_____Qualified Medical Child Support Order
_____Other (Please List)
_____
_____
_____</td></tr>
<tr><td colspan="2">Last Name First Name Middle Initial</td></tr>
<tr><td colspan="2">Street Address</td></tr>
<tr><td colspan="2">City/State/Zip Code/County</td></tr>
<tr><td>Apt/Box/Route Number</td><td>Daytime Phone Number
( )</td></tr>
</table>

Dependent Information: Specify each eligible dependent to be covered, if applicable. Attach additional sheet, if necessary

Dependent's Full Name	Social Security Number	Date of Birth	Relationship

Coverage Change(s) Specify the current Level of Coverage and the new Requested level. Check with your Personnel Office regarding Medical Underwriting. ***NOTE: Please mark Experienced Qualifying Event on any Evidence of Insurability form submitted to Minnesota Life

Employee Life	**Spouse Life**	**Child Life**
_____ Current Coverage Level _____ Requested Coverage Level	_____ Current Coverage Level _____ Requested Coverage Level	_____ Current Coverage Level _____ Requested Coverage Level
Short-Term Disability	**Long-Term Disability**	**Vision**
_____ Current Coverage Level _____ Requested Coverage Level	_____ Current Coverage Level _____ Requested Coverage Level	_____ Current Coverage Level _____ Requested Coverage Level

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Accidental Death & Dismemberment

_____ Current Coverage Level
_____ Requested Coverage Level

Legal

_____ Current Coverage Level
_____ Requested Coverage Level

Dental

_____ Current Coverage Level
_____ Current Coverage Type
_____ Requested Coverage Level
_____ Requested Coverage Type

Long-Term Care

_____ Current Coverage Level
_____ Included Additional Coverage Option (if Applicable)
_____ Requested Coverage Level
_____ Included Additional Coverage Option (if Applicable)

Dependent (Child) Care Spending Account (DCSA)

___ Enroll in DCSA: Monthly Contribution $_____ (monthly)
___ Increase Contribution from $_____ to $_____ (monthly)
___ Decrease Contribution from $_____ to $_____ (monthly)
___ Discontinue DCSA Coverage

Health Care Spending Account (HCSA)

___ Enroll in HCSA: Monthly Contribution $_____ (monthly)
___ Increase Contribution from $_____ to $_____ (monthly)
___ Decrease Contribution from $_____ to $_____ (monthly)
___ Discontinue HCSA Coverage

Specified Illness

_____Current Coverage Level
_____Requested Coverage Level

Spouse Specified Illness

_____Current Coverage Level
_____Requested Coverage Level

Health Insurance *

_____Current Coverage Level
_____Current Coverage Type
_____Requested Coverage Level
_____Requested Coverage Type

*Note: Employees must still complete a State Health Benefit Plan Membership Form and submit to the State Health Benefit Plan. SPA does not approve Health changes.

Authorization: I have read and agree with the Terms and Conditions provided below this form. I certify that the above information and any attachments are true and correct. I understand that any misrepresentation or falsification will subject me to penalties and possible legal action. My signature below authorizes this form to be faxed or mailed to the State Personnel Administration.

Employees Signature _____ **Date** _____

Qualifying Change of Status Form

Terms and Conditions

Policy Information

The Flexible Benefits Program functions as an Internal Revenue Code, Section 125, "cafeteria plan." Under IRS regulations and Rules of the Employee Benefit Plan Council, benefit elections made by employees during an Open Enrollment Period are binding for the duration of the Plan Year. Only under limited conditions of a qualifying "Change in Status" are employees allowed to enroll/ increase or cease/decrease some coverage outside an Open Enrollment Period. A benefit election change will only be permitted if approved by your Department's Benefit Coordinator.

General Information

This form is to be used by an employee who is requesting a change in benefits due to a qualifying "Change in Status." When a Change in Status occurs, the employee is to complete the applicable areas of this form and return it to his/her department within 30 days. Whether you are requesting to enroll / increase coverage, or cease / decrease coverage, the request must be made within 30 days. You must also attach documentation supporting your request. **Please note that if an employee is requesting a change in Health Insurance due to a Qualifying Change in Status, the employee must complete a State Health Benefit Plan Membership Form.** If additional clarification is needed, please call the Flexible Benefits Program at (404) 656-2730, if it is a local Atlanta call, or toll-free at 1 (888) 968-0490, if calling outside the local area.

Effective Date of Change of Coverage

Changes will go into effect the first of the month following the date when the payroll is changed to reflect the employee's new choice.

Qualifying Events

Events that may permit you to enroll or change one or more coverage options:

a) you gain or lose a spouse; or

b) you gain or lose an eligible dependent; or

c) your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or

d) an event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or

e) your change of residence causes you, your spouse, or dependents to gain or lose eligibility for coverage under your plan or another employers plan; or

f) the cost of your Dependent Care increases or decreases significantly and your dependent care provider is not related to you, your spouse, or your dependent; or

g) your spouse's employer increases, decreases, or ceases coverage, or conducts Open Enrollment; or

h) you, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.

For Department Use Only:

Request is: **Approved** _____ **Denied** _____ **Partial Approval/Denial** _____ (Make Comments Below)

Comments _____

_____

Authorized by: _____ Date: _____

Phone Number: _____ E-Mail: _____

Fax to: Flexible Benefits Program
404-463-6379

OR

Mail Copy to: State Personnel Administration
Flexible Benefits Program
2 Martin Luther King Jr. Dr, 1920 West Tower
Atlanta, Georgia 30334